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Private Health Insurance of the Medicare Population and the Baucus Legislation

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The appropriateness of the benefits associated with the private insurance coverage of the Medicare population has been the subject of considerable concern. Section 507 of the Social Security Amendments of 1980, also known as the Baucus legislation, reflects public concerns about the level of benefits in relation to premiums, duplicative coverage, the complexity and difficulty of insurance terminology, and marketing abuses. Data from the National Medical Care Expenditure Survey can provide useful baseline data on the distribution of Baucus-like plans. In 1977, private insurance held by the Medicare population was more likely to cover inpatient than outpatient services and to emphasize "first dollar" benefits for long-term care. Multivariate analyses show that the distribution of Baucus-like insurance policies is highly associated with health status, source of insurance, region, and place of residence. The importance of state regulations, suggested in other research, may account for these patterns. Key words: private insurance; Medicare; Baucus legislation; National Medical Care Expenditure Survey. (Med Care 1985, 23:1086–1096)

The appropriateness of the benefits available through private insurance purchased by the Medicare population has been the subject of considerable concern.[1–4] The number of Medicare beneficiaries covered by private insurance is considerable; two thirds of elderly Medicare beneficiaries had additional coverage by private insurance in 1977, for which they paid $3.8 billion on premiums.[5] Although there have been a number of estimates of the depth and breadth of private insurance coverage sold to the Medicare population,[6–9] many of these estimates have been limited to aggregate statistics on particular populations or on particular benefits. One study has provided national estimates of the private insurance benefits of the Medicare population.[10]

Public concern about the level of benefits in relation to premiums, duplicative coverage, the complexity and difficulty of insurance terminology, and marketing abuses resulted in the passage of Section 507 of the Social Security Amendments of 1980, also known as the Baucus legislation. This legislation provides for federal supervision of state certification of private insurance

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sold to Medicare beneficiaries. The various provisions of the Baucus legislation provide that insurance terminology be standardized and simplified to facilitate public understanding of policies, that there be minimum benefit standards and loss ratio standards to increase the quality of policies sold, and that disclosure provisions be included to prevent marketing abuse.

A major study commissioned by Congress examined the effectiveness of various state regulations applying to Medicare supplemental policies.[11] Although this study also looked at the quality of health insurance policies sold to the Medicare population in 1982, the data were collected in only six states. Since only a small portion of insurance policies held by the Medicare population were examined in this study (4% of policies bought were purchased subject to Baucus), baseline data that might be used to assess the impact of the Baucus legislation on the quality of insurance held by the Medicare population have been lacking. It is the purpose of this report to attempt to fill this gap.

Background

Since its enactment in 1965, Medicare has provided substantial assistance to the elderly in the payment of their medical bills. Nearly all Americans 65 years and older are enrolled in the program.[12] It is estimated that in 1977 Medicare contributed 44.3% of all payments for personal health care for persons 65 years and over.[13] Among the noninstitutionalized, the proportion is somewhat higher (51.7%)[14] but not much different from the 1984 HCFA estimate of 48.8%, which includes Medicare Part B premiums.[15] Still the fact remains that elderly people pay about one fifth of their health care expenses out-of-pocket; the balance is paid by private insurance, Medicaid, and other largely public programs (e.g., CHAMPUS/CHAMPVA).[15]

Medicare was never expected to pay all medical care expenditures of the elderly. Designed like many other insurance programs, Medicare has cost-containment features such as deductibles, co-payments, and co-insurance. Some health services—notably routine dental care, prescribed medicines (out-of-hospital), and most nursing home care—are not covered at all. Private insurance to supplement Medicare has grown in response to these gaps in coverage. In 1967, 45.5% of Medicare beneficiaries also had private insurance[7]; by 1980, private coverage had grown to 67%.[15]

Private insurance supplementing Medicare, like Medicare itself, covers the costs of hospital care more often than the costs of care delivered out of the hospital.[10] Private insurance benefits for services covered by Medicare's Part B and for services not covered by Medicare are generally less extensive than benefits for hospital care and also more unevenly distributed among Medicare beneficiaries. The availability of group insurance has been shown to affect the extent to which private insurance covers the costs of medical care associated with Medicare's cost sharing provisions or related to services not covered by Medicare.[10] Since nearly all of this insurance is employment-related and benefits by law cannot differ on the basis of the age of the enrollee, studies of employment-related insurance can tell us much about this type of insurance.[16–18] Although nearly two thirds of the Medicare population buys insurance in this manner, little is known about the types of insurance policies that are sold directly on an individual basis to the elderly. It is this individually obtained insurance that is the primary focus of legislative concern.

Under the provisions of the Baucus legislation, nongroup insurance policies issued on or after July 1, 1982 must meet certain minimum standards to be labeled or sold as "Medicare supplements." Employment-related group insurance, conversions from

group plans to individual policies, and policies already in effect are exempt. Since its passage, the Baucus legislation has established a minimum standard for private insurance sold to Medicare enrollees in nearly all states. Some states have set additional requirements that are stricter than the minimum standards specified by the legislation, and some states have implemented their regulations prior to the date required by federal law.

The legislation specifies that policies sold as Medicare supplements must contain coverage of all co-payments for hospital days through the Medicare lifetime reserve (under Medicare's Hospital Insurance (Part A), benefits for 60 additional hospital days that can be used whenever a beneficiary has exhausted the 90 days in a covered benefit period), 90% coverage of all Medicare eligible hospital expenses for an additional 365 days after exhaustion of Medicare benefits, and coverage of the Medicare Part B 20% co-insurance, subject to a maximum deductible of $200 and a maximum benefit of no less than $5,000; a policy is not required to cover the Part A deductible, although nearly all do.[10]

A particularly significant impact of the minimum benefit standards will be the extension of private insurance coverage to many outpatient services, such as physician office visits, which is usually not covered by insurance policies sold directly to consumers (i.e., nongroup insurance). Insurers are also required to return to policy holders, in the form of benefits under the policy, at least 75% of premiums collected in the case of group policies and at least 60% of premiums in the case of nongroup insurance. In addition, a policy may not exclude preexisting conditions for more than 6 months or treat illness and injury differently. There are also provisions specifying the conditions under which policies may be cancelable. Since the Baucus rules apply only to new contracts and are not applicable to conversions for group policies, changes in the benefits of the entire privately insured Medicare population will occur only gradually, however.

This report will provide a description of what types of policies were sold to the elderly Medicare population in 1977, who sold plans that would or would not meet the minimum benefit standards of the Baucus legislation, the relative cost of "model" and other plans, and who was more (or less) likely to hold "model" insurance plans prior to the implementation of the voluntary certification program. The purpose of this report is to provide baseline data that can be used at a later date to assess the impact of the Baucus legislation.

Methodology

The data used in this anaysis come from the National Medical Care Expenditure Survey (NMCES). This survey provided detailed national estimates of the use of health services, health expenditures, and health insurance coverage. The survey was undertaken to provide data for a major research effort in the National Center for Health Services Research and was co-sponsored by the National Center for Health Statistics.[19,20]

The characteristics of respondents, including their total and out-of-pocket expenditures for personal health services, were derived from the household survey, the primary source of data for the study. The household survey included 14,000 randomly selected households chosen to be representative of the civilian noninstitutionalized population. These households were interviewed six times over an 18-month period during 1977 and 1978. The population of interest in this article is the subset of all privately insured Medicare enrollees aged 65 and over. This group consisted of 1,843 survey respondents.

Data on private insurance coverage including benefits and type of contract held by the respondent (group or nongroup insurance) were derived from information

TABLE 1. Federal Minimum Standards for Medicare Supplementary Insurance and Indicators of Insurance Coverage used in this Report

Federal Minimum Standards	Indicators
Six months or less pre-existing condition limitation	Six months or less pre-existing condition limitation
Requires coverage of Part A co-payments for 61–90 days of a hospital stay	Full coverage of co-payments for hospital days 61–90 ($31/day in 1977)
Requires coverage of Part A co-payments during lifetime reserve days (91–150)	Full coverage of co-payments for hospital days 91–150 ($62/day in 1977)
Requires coverage of 90% of Part A expenses after lifetime reserve days to a lifetime minimum of 365 additional days (a 515-day stay)	A. Coverage of 80% of Part A expenses after lifetime reserve days to a lifetime minimum of 215 additional days (a 1-year stay) *or* B. Coverage of 100% of Part A expenses after lifetime reserve days to a lifetime minimum of 215 additional days (a 1-year stay)
Requires coverage of 20% of eligible expenses under Part B regardless of hospitalization	A. Coverage of surgery, inpatient physician care, anesthesia, outpatient hospital care, outpatient diagnostic x-ray and laboratory services, physician office visits, ambulance *and* B. Coverage of 20% of expenses for inpatient physician care and physician office visits
Part B maximum of $5,000 per calendar year.	Maximum of $5,000 or 50 visits for either inpatient physician care or physician office visits (or a combined maximum if both are covered).
Maximum $200 deductible for Part B eligible expenses	Maximum $200 deductible for inpatient physician care or physician office visits, whichever is covered.

provided by employers and insurance carriers in the Health Insurance/Employer Survey.[20] Insurance benefit indicators were constructed in a manner described elsewhere.[10]

Several features of the Baucus legislation deal with the quality of insurance plans. These features and the indicators of insurance plan quality used in this report are shown in Table 1. Catastrophic hospital coverage under Baucus is specified as 90% of Part A expenses after the lifetime reserve days to a lifetime minimum of 365 additional days (up to 515 days). Nearly all policies held by the Medicare population in 1977 with coverage beyond 150 days specified hospital benefits at either 80% or 100%. It was therefore decided to use indicators of both of these; also, because in 1977 most policies specified benefits of 365 days or a specified dollar amount (e.g., $40,000), it was decided to use a policy maximum of a 1-year hospital stay (365 days) rather than 515 (as specified under Baucus). This may yield an overestimate of catastrophic coverage relative to the legislation's minimum standard.

Minimum benefit standards required by the Baucus legislation that it was not possible to indicate with these data included 1) the inclusion of a provision automatically linking the policy's cost-sharing provisions to changes in the Medicare program, 2) the standardization of terms used in the policy such as "benefit period," "sickness," or "physician," 3) the loss ratio of the policy (required to be 75% for a group plan, 60% for nongroup plans), 4) a free-look provision, 5) delivery of a buyer's guide and written receipt at the time of application, 6) an outline of coverage requirements, and 7) replacement requirements. There were also no data on the sales approach by which the policy was obtained (mail, phone, in-person agent).

A policy is estimated to be a "model" plan for the purposes of this article if it meets all the minimum standards indicated

TABLE 2. Type of Plans Held by Privately Insured Persons 65 Years and Older Covered by Medicare by Types of Plans Held and Source of Insurance

	All Persons With Medicare and Private Insurance (in thousands)	Percentage of Persons With at Least One "Model" Plan	
		80% Coverage of Hospital Days 151–365[a]	100% Coverage of Hospital Days 151–365
Total	14,335	20.4	19.6
Nongroup plans only	9,118	6.9	6.9
BC/BS only	4,822	10.5	10.5
Commercial only	3,462	0.1	0.1
Other[b]	834	14.0	14.0
Any group plans	5,217	44.1	41.8
BC/BS only	1,563	45.2	44.9
Commercial only	2,078	36.4	31.5
Other[b]	1,576	53.3	52.3

[a] Includes persons with 100% coverage of hospital days 151–365.
[b] Includes persons with both Blue Cross/Blue Shield and commercial coverage.
Source: National Center for Health Services Research.

in Table 1. Because there are two alternative definitions of catastrophic hospital benefits (80% coverage and 100% coverage) used in this analysis, there will be two types of "model" plans—Model A, which provides 80% coverage of hospital care from days 151–365, and Model B, which provides 100% coverage of these days beyond the Medicare lifetime reserve.

Results

In 1977, one fifth of the privately insured elderly Medicare beneficiaries held at least one insurance policy that met the seven minimum benefit standards identified in Table 1 (Table 2). Regardless of how a model was defined, persons with group coverage were more likely to have model plans than were persons with nongroup insurance. If 80% coverage of hospital days 151–365 is used to indicate the Baucus minimum of 90%, about one sixth as many persons with nongroup insurance had model plans as did persons with some group coverage (6.9% versus 44.1%); by the 100% indicator, the difference was about the same (6.9% versus 41.8%). In general, the more liberal definition (80%) resulted in a slight (statistically insignificant) increase in the proportion of group plans identified as model plans over the more conservative definition (100%); this increase is due to the close association of major medical policies with employment-related group insurance.[16] There were no notable differences in the source of model plans except among persons with only nongroup coverage. Persons covered only by Blue Cross/Blue Shield or by both Blue Cross/Blue Shield and commercial plans or other insurance such as HMOs were more likely to have Baucus model plans than were persons covered only by commercial policies.

Because they cover more health services and are more likely to cover the costs of an extended hospital stay, insurance policies fitting the Baucus model could be expected to cost more. Table 3 shows the total annual expense for nongroup health insurance policies held in 1977 by Medicare beneficiaries 65 years and older. Because these plans are not employment-related, insured persons with nongroup coverage pay nearly all of their premium expense out-of-pocket. On average, Baucus model plans cost about two thirds more than nonmodel plans ($237 in comparison with $144). Two thirds of

TABLE 3. Private Health Insurance Premiums for Nongroup Policies Held by Medicare Enrollees 65 Years and Older: Percentage Distributions and Cumulative Percent by Type of Policy and Intervals of Total Premium Expense

Total Annual Premium Expense[a] ($)	Type of Policy			
	Model Plan[b] (n = 691, 089)		Other Plan (13,035,000)	
	Percent	Cumulative Percent	Percent	Cumulative Percent
1–49	00	00	7.0	7.0
50–99	6.4	6.4	37.1	44.1
100–149	7.1	13.5	27.5	71.6
150–199	52.5	66.0	15.1	86.7
200–249	20.2	86.2	4.8	91.5
250–399	4.6	90.8	4.8	96.3
400–699	7.9	98.7	1.7	98.0
700 or more	1.3	100.0	2.0	100.0
Mean ($)	237		144	

[a] Per person premium expense; for couple or family policies, premium was allocated among insured family members.
[b] Covers at least 80% of cost of hospital days 151–365.

model plans cost $150 or more, while 72% of nonmodel plans cost less than $150.

It is interesting to see what particular distributions of benefits were likely to result in a policy not being identified as a model plan. Guttman scaling is a procedure designed to order both items and subjects with respect to some underlying cumulative (single) dimension—in this case, comprehensiveness of insurance coverage.[21] It is possible to use the technique to ascertain if there is any order by which insurance benefits are added as coverage becomes more comprehensive (i.e., more likely to meet the minimum benefit standards). Since virtually all (99%) privately insured elderly Medicare beneficiaries had a policy deductible meeting the minimum benefit standard, the Guttman analysis was restricted to the other minimum benefit indicators in Table 1.

The results of the Guttman scaling and scale statistics are shown in Table 4. This table shows three widely used statistics referring to the scalability of a phenomenon such as depth of coverage—the coefficient of reproducibility, minimum marginal reproducibility, and the coefficient of scalability.[22] The coefficient of reproducibility (CR) varies from 0.0 to 1.0 and is obtained by counting up the number of responses that would have been predicted wrongly for each policy on the basis of its scale score, dividing these errors by the total number of responses, and subtracting the resulting fraction from one; the higher the coefficient, the better the match between the actual distribution and the expected distribution of a perfect scale; values greater than 0.90 are considered to indicate a highly predictable response pattern. Minimum marginal reproducibility (MMR) indicates the reproducibility of a series of items based only on knowledge of the item marginal distributions. The difference (CR − MMR) indicates the improvement in prediction provided by the scale over the marginal frequencies of individual items. The coefficient of scalability (CS) is a measure of the scale's ability to predict item responses in comparison with predictions based on marginal frequencies, values over 0.60 are generally accepted as evidence that a scale is unidimensional and cumulative.

Regardless of how catastrophic hospital

TABLE 4. Guttman Scalogram of Benefits of Private Health Insurance Plans Held by Medicare Population 65 Years and Older

Scale Score	Scale Items	Percentage Distribution	Cumulative Percentage
0	None of following	4.6	4.6
1	Eligibility not restricted for more than 6 months for pre-existing conditions	26.9	31.5
2	Part B Maximum of $5,000 (or 50 visits) for physician office visits and/or physician inpatient visits	16.2	48.0
3	Full coverage of Part A copayments for hospital days 31–60, 61–90	10.4	58.4
4	Full coverage of Part B 20% coinsurance for inpatient physician visits and physician office visits	10.3	68.7
5	Coverage of physician office visits, ambulance physician inpatient visits, outpatient hospital visits, anesthesia, surgery	12.2	80.9
6	Coverage of 80% or more of costs of hospital days 151–365 (after exhaustion of Medicare's lifetime reserve)	19.3	100.0

Coefficient of reproducibility = 0.9.
Coefficient of scalability = 0.7.
Minimum marginal reproducibility = 0.7.
Percent improvement = 0.2.
Unweighted N = 1,075.
Source: National Center for Health Services Research.

coverage was defined (80% or 100%), the three least commonly obtained private insurance benefits in 1977 were coverage of hospital care beyond the lifetime reserve, coverage of all seven Part B services, and coverage of the 20% Part B co-insurance for inpatient and outpatient physican care. The seven Part B services used in this analysis also formed a hierarchy—coefficient of reproducibility of 0.9, coefficient of scalability of 0.7. From least commonly obtained to most commonly obtained, these services form the following scale: physician office visits, ambulance, outpatient diagnostic x-ray and laboratory services, outpatient hospital services, anesthesia, inpatient physician care, and surgery. This pattern may be examined in the context of the elderly's medical care expenses. In 1980, Part B services accounted for 70% of the liability of Medicare beneficiaries. In 1977, when the NMCES data were collected, almost one half (44.4%) of physicians' Medicare allowed charges for medical care derived from physician office visits.[23] However, these data show that on both an insurance policy-level as well as on a person-level,[10] physician office visits are least likely of the Part B services to be covered by private insurance.

A central concern of policymakers in constructing the Baucus legislation was reported accounts of duplicative or excess coverage.[1,2] Testimony revealed accounts of persons holding eight or more different health insurance policies. The insurance data from the National Medical Care Expenditure Survey can be used to explore the extent to which multiple plans might provide full protection against the financial risks associated with illness, although the data set does not allow us to estimate the extent of duplicative coverage.

Benefits of most insurance policies held

TABLE 5. Likelihood of Holding at Least One Baucus "Model" Private Insurance Plan[a]: Logistic Regression Coefficients for Privately Insured Medicare Beneficiaries 65 Years and Older with No Group Insurance

Independent Variables	Coefficient (*t* Ratio)
Intercept	−0.557
Age	−0.017 (0.74)
Sex (Female = 1)	0.503 (1.59)
Perceived health status[b]	
Excellent	0.668[e] (2.14)
Good	−0.040 (0.12)
Limited in activity (Yes = 1)	−0.003 (0.01)
Employed in 1977 (Yes = 1)	0.300 (0.83)
Region[c]	
Northeast	−2.916[e] (3.92)
South	−2.103[e] (3.99)
West	1.534[e] (4.63)
Standard Metropolitan Statistical Area (Yes = 1)	−0.899[e] (3.01)
Source of Insurance[d]	
Blue Cross/Blue Shield only	−0.143 (0.38)
Commercial only	−4.846[e] (5.11)

[a] Dependent variable = Model plan with 80% or more coverage of hospital days 151–365.
[b] "Fair or poor" omitted.
[c] "North Central" omitted.
[d] "Other" insurance omitted.
[e] $P < 0.05$.
Regression equivalent $R^2 = 0.16$.
Source: National Center for Health Services Research.

by the Medicare population most often include coverage of the Part A deductible, surgery, inpatient physician care, and anesthesia. Less often the benefits include outpatient hospital care, ambulance, and physician office visits. Therefore multiple coverage of outpatient physician services (and ambulances) is less likely. Only one third of policies held by this sample of Medicare enrollees covered all seven Part B services identified above, the least covered service being physician office visits. Similarly, coverage of the Part A co-payment for hospital care was more common than coverage of the Part B co-insurance. Thus multiple plans are more likely to provide full coverage of Part A co-payments than provide coverage for the open-ended expenses associated with use of Part B services; having a second policy won't substantially improve coverage of Part B services.

The availability of group insurance to the Medicare population largely depends on the primary insured's current or former employer.[18] Because of lower administrative costs and high employer contributions, catastrophic benefits and coverage of outpatient services including physician office visits, diagnostic services, and prescribed medicines are typical of these plans.[10] Among privately insured persons who do not have access to group insurance, however, sociodemographic factors associated with the availability of Baucus model plans have been explored. Approximately 7% of elderly Medicare enrollees with nongroup insurance had Baucus-like plans. In order to show what factors affected the likelihood of a person holding a Baucus-like plan, multivariate analysis was used. Factors expected to be associated with the likelihood of holding a model plan included demand and supply variables such as age, sex, indicators of health status, income, region, and place of residence (SMSA/non-SMSA), as well as source of insurance (Blue Cross/Blue Shield only, Commercial only, other). Place of residence was included because of the association of HMO coverage with residence in metropolitan areas.[25] Preliminary analyses showed no income effect.

Final logistic regression estimates of factors associated with the likelihood of holding at least one Baucus model plan among this population show that health status, geographic region of residence, place of residence (SMSA or not), and source of insurance largely determine the availability of model plans (Table 5). Reflecting insurance principles, persons in "excellent" health were more likely to have model plans than were persons in "fair" or "poor" health. The impact of region can be seen in the fact that fully one fifth (20.3%) of

elderly Medicare beneficiaries with nongroup insurance living in the West had a Baucus model plan (covering at least 80% of the costs of a year long hospital stay) in comparison with 6.9% nationwide (data not shown). This reflects both the statistical prevalence of HMO coverage in that region as well as the likelihood of private insurance responsiveness to the presence of HMOs.[24] Model plans were also more common among privately insured persons with nongroup insurance residing in the North Central region (9.5%) than in the South or Northeast (1.5% and 0.8%, respectively). However, persons residing in Standard Metropolitan Statistical Areas (SMSAs) were less likely to hold model plans than were Medicare enrollees residing elsewhere. Interestingly, age, sex, and limitation of activity did not seem to affect the likelihood of holding one or more model plans. These patterns were also found when the dependent variable specified 100% coverage of days 151–365 (data not shown).

It is important to note that the amount of variance explained in this equation is not particularly high (16%), indicating that characteristics of the primary insured are not sufficient to explain whether a privately insured person has a Baucus model plan or not. On the other hand, the importance of insurance source and region suggest that marketplace factors and state insurance regulations are very important determinants of the breadth and depth of private insurance sold to Medicare beneficiaries.[11]

Discussion and Conclusions

Two thirds of Americans 65 years and older are covered by private health insurance in addition to Medicare. Although approximately one third of privately insured Medicare beneficiaries obtain their insurance through current or former employers, the majority buy their insurance directly from insurers. Data from the National Medical Care Expenditure Survey have been used to compare the benefits available through this insurance with benefits required under provisions of the Baucus legislation, a voluntary state certification program enacted as part of the Social Security Amendments of 1980. This analysis provides baseline data useful in assessing the impact of the Baucus legislation and in explaining sources of variation in the breadth and depth of the Medicare population's private insurance coverage.

Regardless of where private insurance held by elderly Medicare beneficiaries was obtained, that is whether through groups or directly from insurers, it was more common to find coverage for inpatient than outpatient services and for short-term than long-term hospital stays. Group policies in 1977 were more likely to offer benefits consistent with the requirements in the Baucus legislation than were nongroup plans. Reflecting their more comprehensive benefits, Baucus model plans cost more than other types of policies; the likelihood of holding a model plan increased with total annual premium; premiums for model plans held by persons with nongroup insurance averaged two thirds higher than premiums for other insurance plans.

Multivariate analysis showed that among persons with nongroup insurance, those with only commercial plans were less likely to have model plans than were persons covered only by Blue Cross/Blue Shield or by other insurance (including persons with HMO coverage and persons with both Blue Cross/Blue Shield and commercial plans). Regional and place of residence variations in the distribution of model insurance plans were extremely strong. Elderly Medicare recipients with nongroup insurance were twice as likely to have model plans if they resided in the West than in the North Central region of the country. The proportion of insured persons in the East or South with individual plans in conformance with

model plans was extremely small, less than 5%. Persons residing in metropolitan areas were less likely to have model plans than were persons residing in nonmetropolitan areas. Better health status was also a positive correlate of holding a Baucus model plan.

With implementation of the Baucus legislation as part of the Social Security Amendments of 1980, there will be substantial alterations in the distribution of private insurance benefits. State regulations, as demonstrated in other research,[11] can be expected to alter significantly the availability and cost of nongroup insurance. The coverage of ambulatory health services and of long-term hospital stays will probably increase among persons who buy their insurance directly from insurers, particularly in the Northeast and Central regions of the nation, as well in metropolitan areas. The data in this report will provide a useful baseline to assess the magnitude of these changes in private insurance coverage for the Medicare population.

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